

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 11/29/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445464	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 11/27/2012
NAME OF PROVIDER OR SUPPLIER HILLVIEW HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1666 HILLVIEW DRIVE ELIZABETHTON, TN 37643	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 021 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of:</p> <p>a) the required manual fire alarm system;</p> <p>b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and</p> <p>c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure corridor doors closed to a positive latch. (NFPA 101, 19-3.6.3.)</p> <p>The findings include:</p> <p>Observation and interview with the Maintenance Director, on November 27, 2012 at 10:00 a.m. confirmed the corridor door by 101 failed to close to a positive latch.</p> <p>This finding was verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on November 27, 2012.</p>	K 021	<p>Parts ordered by Maintenance Supervisor on 11/28/12 to repair corridor door. Repair to be completed upon receiving parts by the Maintenance Supervisor.</p> <p>The Maintenance Supervisor checked all corridor doors on 11/27/12. No other doors were found to be affected.</p> <p>The Maintenance Supervisor was in-serviced on 11/27/12 by the Administrator on positive latching of the corridors doors.</p> <p>The positive latch on the lobby corridor door will be checked weekly and coincide with the door lock tests that are currently being conducted weekly to ensure positive latch is working properly by the Maintenance Supervisor ongoing. Results obtained will be reported to the Quality Assurance/Performance Improvement Committee. The Quality Assurance/Performance Improvement Committee consists of the Administrator, the Director of Nursing, Minimum Data Set Coordinator, Rehabilitation Manager, Medical Director, Social Services Director, Environmental Services Director, Maintenance Director, Dietary Manager, and the Activities Director.</p>	12/31/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

*Joshua Cannon**Administrator**12-17-12*

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NAME OF PROVIDER OR SUPPLIER HILLVIEW HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1666 HILLVIEW DRIVE ELIZABETHTON, TN 37643	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 038 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure not more than one delayed egress door was in the path of egress. The findings include:</p> <p>Observation and interview with the Maintenance Director, on November 27, 2012 at 10:50 a.m. confirmed the main entry doors and corridor doors by 101 were locked with a delayed egress maglock resulting in 2 doors in the path of egress on a 15-second delay.</p> <p>This finding was verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on November 27, 2012.</p>	K 038	<p>K038</p> <p>MagLock was reprogrammed to appropriate delay on 12/3/2012 by Maintenance Supervisor.</p> <p>The Maintenance Supervisor checked all egress doors on 12/3/12. No other doors were found to be affected.</p> <p>The Maintenance Supervisor was in-serviced on 12/3/12 by the Administrator on proper egress door procedure.</p> <p>The egress door will be checked weekly and coincide with the door lock tests that are currently being conducted weekly to ensure positive latch is working properly by the Maintenance Supervisor ongoing. Results obtained will be reported to the Quality Assurance/Performance Improvement Committee. The Quality Assurance/Performance Improvement Committee consists of the Administrator, the Director of Nursing, Minimum Data Set Coordinator, Rehabilitation Manager, Medical Director, Social Services Director, Environmental Services Director, Maintenance Director, Dietary Manager, and the Activities Director.</p>	12/31/12
K 052 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4</p>	K 052		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445484	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 11/27/2012
NAME OF PROVIDER OR SUPPLIER HILLVIEW HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1666 HILLVIEW DRIVE ELIZABETHTON, TN 37643		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 052	Continued From page 2 This STANDARD is not met as evidenced by: NFPA 72, 7-3.2.1 Detector sensitivity shall be checked within 1 year after installation and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate that the detector has remained within its listed and marked sensitivity range (or 4 percent obscuration light gray smoke, if not marked), the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector-caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or in areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed. Based on record review, the facility failed to assure smoke detectors were tested for sensitivity every two (2) years (NFPA 72-7-3.2.1). The findings include: Record review on November 27, 2012 at 9:55 a.m confirmed the last sensitivity for smoke detectors was conducted January 2010 with 3 failures to detectors #1, #34, and #35. The detectors were replaced, however the facility failed to have them tested for sensitivity one year later. These findings were verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on November 27, 2012.	K 052	K052 East Tennessee Fire Alarm was contacted on 12/11/12 to schedule sensitivity test by the Maintenance Supervisor. Sensitivity test to be completed by 12/31/12. All detectors will have the sensitivity test completed by 12/31/12 by East Tennessee Fire Alarm. The Maintenance Supervisor was in- served on 12/11/12 by the Administrator on proper fire detector testing. All detectors in facility will be tested weekly X 4 weeks and then monthly thereafter. If any failures are reported as a result of the sensitivity test they will be replaced and another yearly sensitivity test will be scheduled to ensure compliance. Results obtained will be reported to the Quality Assurance/Performance Improvement Committee. The Quality Assurance/Performance Improvement Committee consists of the Administrator, the Director of Nursing, Minimum Data Set Coordinator, Rehabilitation Manager, Medical Director, Social Services Director, Environmental Services Director, Maintenance Director, Dietary Manager, and the Activities Director.	12/31/12	
K 056	NFPA 101 LIFE SAFETY CODE STANDARD	K 056			

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NAME OF PROVIDER OR SUPPLIER HILLVIEW HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1666 HILLVIEW DRIVE ELIZABETHTON, TN 37843		
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K 056 SS - D	<p>Continued From page 3</p> <p>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure all areas were sprinkled. The findings include: Observation and interview with the Maintenance Director on November 27, 2012 at 1:30 p.m. confirmed two crawl spaces were not sprinkled and used for storage. (NFPA 13, 5-13.1.1). This finding was verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on November 27, 2012.</p>	K 056	<p>K056</p> <p>All storage will be removed from the two crawl spaces by the Maintenance Director by 12/31/12. The crawl space access will remain locked and a notice will be placed at this access preventing anyone from using as storage due to the absence of a sprinkler system in the crawl space. The Maintenance Director will add this to his monthly checklist to ensure crawl space access remains locked and is free of any storage items.</p> <p>All crawl spaces checked by the Maintenance Supervisor on 12/11/12. No other crawl spaces found to be affected.</p> <p>The Maintenance Supervisor was in-serviced on 12/11/12 by the Administrator on proper storage areas.</p> <p>All crawl spaces will be checked weekly X 4 weeks and then monthly thereafter by the Maintenance Supervisor ongoing. Results obtained will be reported to the Quality Assurance/Performance Improvement Committee. The Quality Assurance/Performance Improvement Committee consists of the Administrator, the Director of Nursing, Minimum Data Set Coordinator, Rehabilitation Manager, Medical Director, Social Services Director, Environmental Services Director, Maintenance Director, Dietary Manager, and the Activities Director.</p>	12/31/12	